HEALTH HISTORY FORM

School Health Program

This form should be filled out by the child's parent or legal guardian. Return the completed form to your child's school nurse.

Name of Child_____ Date of Birth_____ Sex: ☐ Male ☐ Female Grade_____ Rm #_____

Address_____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1: Name_____ Email_____

Tel # (H)_____ (C)_____ (W)_____

Parent/Guardian #2: Name_____ Email_____

Tel # (H)_____ (C)_____ (W)_____

Emergency contacts: Name_____ Relationship:_____ Telephone #:_____

Name_____ Relationship:_____ Telephone #:_____

MEDICAL HISTORY

Health concerns: Does your child have any health concerns the nurse needs to be aware of? ☐ Yes ☐ No

If YES, please describe._____

Can your child participate in all school activities? ☐ Yes ☐ No

Allergies: Does your child have any allergies? ☐ Yes ☐ No If YES, what is your child allergic to? _____

Does your child carry an Epi Pen? ☐ Yes ☐ No

Medication: Does your child currently take medications? ☐ Yes ☐ No If YES, what medicine?_____

Past medical history: Date of last doctor's visit _____

Does or has your child received medical care for any of the following:

☐ Asthma ☐ Diabetes ☐ Kidney Disease ☐ Orthopedic ☐ Other _____

☐ Concussion/Head injury ☐ Heart Disease ☐ Mental Health ☐ Seizure

MEDICAL PROVIDER INFORMATION

Primary care provider: Name_____ Clinic/Practice Name _____

Dentist: Name_____ Clinic/Practice Name _____

Other provider: Name_____ Clinic/Practice Name _____

Health insurance type: ☐ Mass Health ☐ Private Insurance ☐ Other_____

If you do not have a doctor or health insurance: Would you like assistance finding a health care provider? ☐ Yes ☐ No

Would you like assistance obtaining health care insurance? ☐ Yes ☐ No

PARENT/GUARDIAN CONSENT

The school nurse has permission to share information with school staff as s/he determines appropriate for my child's health and safety. ☐ Yes ☐ No

The school nurse has permission to share and receive the following information about my child with my child's health care provider:

Prescribed medications ☐ Yes ☐ No

Mental health/counseling concerns ☐ Yes ☐ No

My child's medical conditions ☐ Yes ☐ No

Other: _____

Parent/Guardian Signature	Please Print Name Here	Date
_____	_____	_____

School health services are provided to CPS through a collaborative agreement with the Cambridge Public Health Department.

Cambridge Public Health Department